CORE- Mailroom Verify

Purpose:

The various types of claims received at the Iowa Medicaid Enterprise (IME) building are sent through the Verify system for processing after they have been scanned. They are automatically assigned a priority number or the person scanning the claim can assign it a different priority number. The Verify system will attempt to capture any information for processing through Optical Character Recognition (OCR). There are two separate exchanges in which the claims can go to for processing (Exchange 7 and Exchange 8). The various claim types are assigned an exchange and will only go to that exchange. There will be only one claim type within each job in the exchange.

Identification of Roles:

Data Entry/Imaging Technician (DE/IT) and Data Entry Specialist (DES) – perform verification on claims

Quality Analyst – perform quality assurance checks on specified aspects of the verification process

Operations Coordinator, Operations Team Lead, and Operations Manager – operate as a resource for verify functions; implement process changes as needed

Performance Standards:

Data enter ninety-eight percent (98%) of all hard copy Claims and Adjustment/Void Requests within five (5) business days of receipt.

Path of Business Procedure:

Step 1: Log into the Verify system

Step 2: Choose an exchange based off of which one has the oldest Julian Date and select a job.

Step 3: Claim will appear

a. The first claim will appear on the top half of the screen.
b. The information that was OCR'd will appear on the bottom half of the screen.

Step 4: Compare image to the OCR read

a. Press "Enter" if the OCR read was correct to advance to the next field
b. Manually key the correct information if the OCR read was incorrect and then press "Enter" to advance to the next field
c. Repeat these steps for every field that needs to be reviewed

Step 5: Review attachments for additional pages that may need to be manually keyed

Step 6: Reject claims if needed

a. Return to Provider (RTP)
b. Rescan

Step 7: A designated percentage of the claims will go to Pre-verify Quality Assurance for a quality check.

Step 8: The claims will then go through a set of rules to determine if the information captured meets specific guidelines. If not, the claim will go to post-verify.

Step 9: A designated percentage of the claims will go to Post-verify Quality Assurance for a quality check.

Step 10: Completed claims are then uploaded into the Medicaid Management Information System (MMIS) nightly.

Forms/Reports:

Show Claim Age by Upload Date Range report- created monthly
Upload Age Spreadsheet- created monthly

RFP References:

5.2.2.3.7.1.1, 5.2.2.3.4.1.2 – 5.2.2.3.4.1.8

Interfaces:

Verify System, Transform Manager, MMIS

Attachments:

Upload Age Spreadsheet

DAILY	DO NOT ENTER IN THE YELLOV		
	1-Jul	2-Jul	6-Jul
met standard			
HCFA			
Pt B xover			
UB			
Pt A xover			
Dental			
TMC			
Total	0	0	0
did not meet standard			
HCFA			
Pt B xover			
UB			
Pt A xover			
Dental			
TMC			
Total	0	0	0
Percent that met standard (98%)			
HCFA			
Pt B xover			
UB			
Pt A xover			
Dental			
TMC			
Total			
MONTHLY			
	Jul '10	Aug '10	Sep '10
Total claims that met standard			
HCFA	0	0	0
Pt B xover	0	0	0
UB	0	0	0
Pt A xover	0	0	0
Dental	0	0	0
TMC	0	0	0
Total	0	0	0
Total claims that did not meet standard			
HCFA	0	0	0
Pt B xover	0	0	0
UB	0	0	0
Pt A xover	0	0	0
Dental	0	0	0
TMC	0	0	0
Total	0	0	0
Percent that met standard (98%)			
HCFA			
Pt B xover			
UB			
Pt A xover			
Dental			
TMC			
Total			